say that for some individuals, the condition of gender incongruence creates distress and creates problems in living.

Q What is the difference, Doctor, between severe and nonsevere gender dysphoria?

A Severe gender dysphoria -- like most of your conditions, other medical conditions, gender dysphoria exists on a continuum, just like, for example, diabetes. Some people can have no diabetes, they can metabolic syndrome, they can have type 1 diabetes or type 2 diabetes. Diabetes that occurs early in life, type 1, is far more severe than late-onset diabetes.

Similarly, with gender dysphoria, individuals who have severe gender dysphoria, it typically appears earlier in life, free -- before secondary sex characteristics emerge, and it tends to be more severe in the sense that it requires treatment, whereas individuals who have less severe forms or aspects of gender incongruence often don't require treatment.

Q And do you have any authority for establishing there is a -- the spectrum of dysphoria from severe to less severe?

A Well, Harry Benjamin first -- he was the first person to identify the condition, did delineate that, those levels of severity.

Q And so would WPATH have a discussion about severity levels?
A Not -- they don't talk about severity levels per se. They talk about options for treatment dependent on the severity, which depend on the severity of the dysphoria.
Q Do you have your report in front of you, ma'am?
A I do.
Q Okay. If you could look at page 9 through 10. Are you there?
A I have 10. I'm looking for 9.
Q Okay.
A Just one moment, please. All my pages are mixed up now, so this may take a minute. I'm not trying to create suspense.
MR. FALK: Well, if it's any consolation, we're not in suspense, so --
MR. CARLISLE: Speak for yourself.
MR. FALK: Okay. Sorry. You're right. And Gavin and Bradley's.
A So there's 10. And you said 9 and 10, correct?
Q Yes.
A Okay. I now have it.
Q All right. Starting at the bottom of page 9, you write, under the contemporary understanding of gender

identity, transition-related medical treatments confirm, not change, an individual's sex by aligning primary and secondary sex characteristics with the person's gender identity.

What do you mean when you say contemporary understanding?

A What I mean is that a person cannot turn off or change their gender identity because our contemporary understanding is that this is an in-born, brain-based condition, and so therefore one cannot alter it, and henceforth conversion therapies are unethical.

Q When you say contemporary, how long has this contemporary understanding been around?

A Well, in 2000, the first studies were done where actual brains were visualized and the New York Times reported on that, and it was -- it had always been presumed as a possible hypothesis of the origin of gender dysphoria since it had existed since time immemorial and existed throughout the world that perhaps -- and a child, different childrearing habits, did not impact the development of it, no one had been cured of severe gender dysphoria through psychotherapy, so there were always researchers who posited that it was a biological condition, and in 2000, some brains were examined postmortem. Now, the

ability to examine brains postmortem obviously had limitations because, No. 1, the people were dead, and you couldn't collect a lot of brains, and also you couldn't determine whether the differences that were visible in those brain structures, predominantly in the BSTc area of the brain, that's what they looked at, was that a result of hormones that they took, or was that there prior to hormones.

So even though researchers in 2000 saw significant differences in areas of the brain, questions remained; however, with advances in technology, particularly functional magnetic resonance imaging, it was possible to study brains of living people prior to the initiation of hormones and thus give information that settled that question.

Additionally, researchers from all over the world, geneticists and people who studied alleles, polymorphisms, people who study EEG irregularities, there -- with the advent not only of advanced technology but the computer, which allowed for these people to do these -- gather a great number of studies and combine, primarily in Europe where it's easier to conduct research of this type than in the U.S., there was a barrage of information demonstrating significant and conclusive indications of biological nature of

gender dysphoria.

Q So when you use contemporary here on page 9, do you mean new or in development?

A You mean our current? It used to be a hypotheses. It's now established that this is the etiology, and even the DSM-5 talks about twin studies. So, for example, as I mention in my report, siblings are five times more likely to have a sibling who also has gender dysphoria, and there -- it runs in families. Twins, even twins raised apart, have a high concordance for gender dysphoria, and even in 2012 when the DSM-5 was published, they do note that in there, and of course we've come a long way since 2012 in terms of the research in this area.

Q Okay. Is there any debate in the medical community about the biologic origins of gender identity?

A I think that there -- I don't think that there's much debate about the biological origins. I think that there are people who are examining this from different perspectives. So there may not be one unifying theory, but we know for instance that white matter, gray matter, subcortical structures differ, and all of that research is just well accepted. It's -- there's, you know -- there's no debate about that when you look at the brains and when you look at that, that's --

that's conclusive, and that is methodologically sound. And it's reported in journals where, you know, some people wouldn't normally read, but I've documented some of the most recent of those studies because I collaborate with an individual in Spain who's done quite a bit of work, if not most of the work, in the area of brain and cerebral right hemisphere differences in gender dysphoric individuals.

Q Is your opinion here or anywhere, is it your opinion that transition-related medical treatments do not change a person's sex?

A Would you repeat that?

Q Yeah. Do transition-related medical treatments change a person's sex?

A Medical treatments don't change a person's gender identity. It can confirm it.

Q So does that mean that -- is it possible to change someone's gender identity then?

A Is it possible to change someone's gender identity? No. Gender identity is -- is an innate part of a person's personality. Some people experience incongruity between the gender identity and their body morphology or the sex they're assigned at birth, and for some people that incongruity is so severe that they do require some body modification in order to

bring into congruence their gender identity and their body morphology.

Q So if I understand you, is gender identity a fixed immutable category?

A For most people, it is. There are people who say that they are, for instance, nonbinary. They may fall somewhere on the continuum, they don't identify as male or female, but their gender identity is nonbinary. There may be some people who say that they can alter their gender identity, but those are not the people that are typically seeking treatment.

Q Doctor, what if you had a transgender patient who in the past identified as a man but now identifies as a woman? Given that gender identity is fixed, would that indicate to you the person's identity is -- is what? What would that indicate to you about that person's identity?

A It wouldn't indicate anything to me about that person's identity. I mean individuals who experience some degree of gender incongruity can -- depending on their age and the circumstances, the circumstances of their life and how much distress it causes them or nondistress. So for example, in some cultures, individuals who are born male are -- but prefer to live as females and identify as females are accepted

into the society, and they don't experience any distress. So there's also a condition called guevedoces where -- which is an intersex condition which doesn't become apparent until puberty, so children are raised as girls, and then at 12 or 13, they develop testicles and are living -- and live as boys, and that's very common in one particular area of the Dominican Republic, and that's just part of the culture.

So how a person experiences or doesn't experience incongruity is a very individualized situation.

Q If gender identity is fixed, how can someone identify as a man for some point of a life and then later identify as a woman? That seems like a contradiction.

A Well, what if that person doesn't know that there's such a -- that they have the ability to live as a woman? I had a patient who was 87 years old who married, he had children. His wife left him because she didn't think he was manly enough. He raised three daughters. He was brilliant. He spoke seven languages. One day he went to the doctor when he was 87 years old, and she told him he had an elevated PSA, and she said one of the treatments for that is to give you estrogen, but I'm sure you wouldn't want that because that would turn you into a female, and all of

a sudden a light went off into his head. He literally danced down the street because for the first time in his life, his life made sense to him.

Eighty-seven years ago, nobody knew that there was a possibility of living in a gender other than the one you were assigned at birth. Christine Jorgensen didn't appear until she -- that was the first time Americans became aware of his phenomena. So people may have felt that they enjoyed female things or they liked cooking or they were, you know -- felt more feminine, they wanted to play with girls, but there were no medical options available for them. There was no internet. They didn't know that there was any resources.

Q Sure. But you're assuming the person doesn't know. What if the person does know about transgenderism and still identifies as different genders throughout his or her life? I mean --

A Some --

Q -- isn't that a contradiction with what you said, that gender identity is fixed?

A No. Some of those people furtively, furtively live as women, they work as men, but they express their femininity when they can. Gender dysphoria intensifies with age, so there are people who are able

to sort of squelch some of these feelings, and then as they get older and DHA rises and there's some chemical changes in the brain, they become destabilized, and they do have to live in their authentic gender.

THE WITNESS: Excuse me. I would like to take a short break and get some water.

MR. CARLISLE: All right. Let's go off the record.

MR. FALK: Thank you.

(A discussion was held off the record.)

BY MR. CARLISLE:

Q Okay. We're back on the record.

Dr. Ettner, if I'm understanding you correctly, in our example of a transgender patient who's had knowledge of transgenderism and who has identified as different genders at various portions of his or her life, does it require a physiological biological change every time that person changes genders?

A No.

Q But I thought gender identity was biologically determined.

A Yes, but, for example, a person who has a degree of gender incongruence, they consider themself gender nonconforming or they may consider themself a cross-dresser. So at times they feel inclined to

appear as a female and to express that part of their gender identity, that female gender identity, but they don't --

(Technical interruption.)

(Reporter clarification.)

A But they don't desire to modify their body. They don't have a severe form of the condition, they don't have gender dysphoria. They have a degree of gender incongruence, but it is not severe, so they can live in their assigned sex, but they do experience some degree of gender incongruence.

Now, for other people, they may find that they want to take hormones and a small dose of hormones may make them feel comfortable, and they can live with just in a way demasculinizing with taking an antiandrogenic substance. These are -- everything in medicine is individually based, and people are different.

Q It seems like you added one more condition to our hypothetical, which is if -- it might not be biologically determined if you have a nonsevere form of gender dysphoria, but what about someone with a severe form of gender dysphoria, knowledge of transgenderism, who has expressed different gender identities at various points of his or her life? How

can that be if gender identity is biologically determined?

A I don't understand the question, and I think perhaps I'm not explaining the answer well.

So gender incongruity is biologically based; however, like all medical conditions, it appears on a continuum. Not everybody has a severe form. So some people can have hypothyroidism to such a small degree that they don't require treatment. Other people can have Graves' disease and require massive treatment. So you either have a condition or you don't, and then you have it to a certain degree.

Now, there are people who socially transition. So, for instance, I have had clients over the years who have been gender dysphoric, they've taken hormones, and they meet a woman, and they fall in love, and they decide that they want to get married, and so they go off hormones and they get married, and if they have a severe form of gender dysphoria, they act -- delusion does not work, and ultimately the marriage fails, they return, they resume hormones, and in some cases they have gender-affirming surgery.

So there are children -- and I realize this case is not about children, but there are children who transition and are simply ridiculed and, you know,

society is very difficult for them, so they -- they revert to living in their -- in their assigned gender. So there are many reasons why people might not always express their gender identity, and if it is severe, however, they will have to express it. Severe gender identity is -- it is a serious medical condition, and people will go to the ends of the earth. Literally people used to go to Morocco to Casablanca before there were surgeons in the United States performing the surgery.

Q Okay. Thank you.

WPATH provides for a number of various treatment options for dysphoria; right?

A For gender incongruity, yes. Yes, correct.

Q And WPATH allows for the exercise of independent medical judgment?

A I don't understand that. Could you rephrase that?

Q Yes. Does WPATH encourage mental health professionals to exercise independent medical judgment when treating gender dysphoria?

A WPATH has guidelines and outlines what the tasks of the mental health professional are and what the requirements are for individuals who initiate hormones or who initiate surgery, so there are some necessary but not necessarily sufficient conditions for the

treatment options, and WPATH outlines -- it's shared decision-making. We work in multidisciplinary teams, and we consider that shared decision-making. Patient alone doesn't make the decision; patient makes it with providers.

Q So does WPATH allow for the exercise of independent medical judgment when treating gender dysphoria?

A I'm still -- I'm still not understanding the question. Whose independent medical judgment?

Q Treating medical professionals, mental health professionals.

A Well, mental health professionals can evaluate an individual and do evaluate individuals prior to surgery if you're talking about surgery. If you're talking about hormones, physicians who feel comfortable and who have experience prescribing hormones can initiate hormones without mental health input.

Q Can two medical professionals determine two different courses of treatment for gender dysphoria while both relying on WPATH?

A In regards to the same patient?

Q Yeah.

A Would you repeat that question? Sorry.

Q Can two different medical professionals prescribe two

different courses of treatment when treating the same individual in accordance with WPATH?

A Are those medical professionals from the same discipline or different disciplines? For example --

Q Same.

A Same? That would be unlikely if they are specialists in this highly specialized area. So, for example --

Q But possible?

A I think anything is possible, but, for example, a surgeon may determine that a patient is too obese for him to consider surgery, even though the patient medically requires it, and another surgeon may say, I'm comfortable doing surgery; even though the patient is obese, I still believe that I can accomplish the surgery, and I'm willing to provide it. So surgeons have different comfort levels with -- in terms of those kinds of parameters, so they would agree that the surgery is necessary, but they may disagree on their willingness to perform it.

Q Let's narrow it down a little bit more. Under WPATH, can two reasonable medical professionals come to different conclusions about whether surgery should be a treatment option from the same patient?

A It's -- if they are from different disciplines, that's not uncommon, and that's why we work in

multidisciplinary teams. So, for example --
Q And from the same discipline?
A I think from the same discipline, it's possible. Two endocrinologists may feel that the patient's hormones are not consistent enough or have not been -- are not in an appropriate level to initiate surgery, and they may want to alter the endocrinological protocol. Two psychologists, one who's been following the patient for years and one who is a specialist, may differ on whether the patient is a candidate or whether they are eligible.
Q Okay. Doctor, if you could look at page 10 of your report, Exhibit 45.
A Yes, I'm there.
Q Okay. Do you see the paragraph starting genital reconstruction surgery?
A Yes.
Q You write, genital reconstruction surgery for transgender women has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, the patient attains body congruence, resulting from the urogenital structures appearing and functioning as is typical for non-transgendered women.
Doctor, focusing on the first purpose you

identify, if I could rephrase that, and tell me if I have a correct understanding. Are you saying that eliminating the testes, which are the organs that produce the testosterone in the body, will result in a hormonal level that's like a natal woman? Is that why that surgery is a purpose under that first prong?

A You're partially correct and partially incorrect.

Q Okay. Can you explain?

A Yes. So the testicles are the target organ that produce androgens, which kindle the gender dysphoria. Now, when you give antiandrogen hormones to people, you lower the testosterone levels; however, that is a completely different path of physiology than actually removing that target organ. So the removal of the target organ is a very significant reduction in gender dysphoria, far more -- far more efficacious than a chemical, trying to chemically suppress testosterone. You're just removing the target organ entirely. That's why we see, consistently in the prisons, individuals attempting to remove the testicles because by doing so, they would have -- they would alleviate the testosterone that is really, in a sense, poisoning them.

Q Now, at page 22 of your report, you note that the plaintiff has been hormonally reassigned; right?

A Correct. Correct.
Q So I'm just trying to understand that. If she has the same circulating sex hormones as a female, then removing the testicles has the same effect as the hormone treatment?
A No, it doesn't, though.
Q Why not?
A So the levels will be similar, but the -- but the phenomenology, the psycholo- -- the feeling will be different. So, in other words, when you chemically suppress hormones, you are -- hormones vary. They're -- you know, they're not always exactly steady, they vary. So when you chemically suppress them, you try to find a level that keeps a person in a certain range, but when you remove the testicles all together, people have a completely different response than with a chemical suppression.

So I'm trying to think of an analogy, and I don't think I can really think of a good one, but it's -- you're -- you are altering -- hormones work primarily on the brain due to a feedback system. They affect every organ system in the body. When you remove that target organ, you completely alter the individual's feelings, so they experience less gender dysphoria because they're not -- it's like pushing against a

mountain when you try to suppress testosterone, but when you eliminate the target organ, people just immediately feel better.

Q So if I'm following you, the difference between surgical removal of the testes and a hormone regimen that will provide the same hormone profiles in a natal female, is that surgery helps with the feeling of it, whereas hormones does not affect the feelings?

A No. Hormones do affect the feelings, but not to the same extent. So you could still have erections with the -- with a chemical suppression. You still have -- you know, you can still have some androgen production despite taking the antiandrogens. So you will reduce the testosterone, you'll change the ratio of the estrogen to testosterone, but it won't be as dramatic or as impactful or as efficacious as removing the organ. So there's a difference in giving a woman -- in doing a hysterectomy, removing those organs, and taking birth control pills, for example.

Q So surgical removal of the testes is more efficacious than hormones because -- because the feeling of incongruence is addressed better when the organ is removed?

A Yeah, I think that's fair to say. I would say that, yes; and additionally, people who have gender

dysphoria will tuck their testicles so that they don't have to view them. They'll try to often insert them back into the body cavity. After a while, people will experience testicular pain from tucking, and so that's another reason why people are pleased when they no longer have testicles, but basically it is a different pathophysiology of the removal of the organ and a chemical suppression, and one is more effective in attenuating gender dysphoria.

Q Okay. So that assumes that someone is tucking testicles back into the body cavity; right?

A Or tucking them in some other way and wearing a tight garment, which is often the case.

Q All right. Let me ask you about your second identified therapeutic purpose of surgery, which is the patient attains body congruence resulting from the urogenital structures appearing and functioning as is typical for non-transgendered women. Now, isn't that the feelings prong you're talking about? In other words --

A If you're a woman -- if you're a woman, you don't want to have a penis and testicles. You want to have your primary sex characteristics and your secondary sex characteristics consistent with your gender identity. That is by definition the diagnosis of gender

dysphoria, the desire to be rid of the primary and/or secondary sex characteristics. A person who has been hormonally reassigned, and remember hormones act primarily on the brain, so a person who is living as a female and has male genitalia is going to be vastly distressed, and they are going -- if they have severe gender dysphoria, they are going to experience distress that is going to intensify with time and age, and they have no means of -- they have no way to resolve that themself. They can't -- they can't rid themselves of those organs. They need surgical help or else they just, what, amputate their organs themselves, which unfortunately some people have done.

Q So the second purpose you've identified, is it that whether one has attained bodily congruence, the feeling of congruence, is that based on the appearance or the presence of the genitals?

A A gender dysphoric person detests their genitalia. They have severe anatomical dysphoria around their genitals. They don't want to touch their penis. They don't want to look at it typically. They don't -- they despise it. It feels inappropriate. It doesn't belong there. It's not part of them. It's what psychologists refer to as egodystonic, so they feel female, they have some breast tissue, they -- if

they're lucky they can appear as female. Even in a prison situation they have some social accoutrements, they can change their name, but they cannot rid themselves of their primary sex characteristics, and that is the torment of gender dysphoria.

Q In your report, I believe you suggest that the plaintiff's medical professionals did not have sufficient experience to treat gender dysphoria; is that accurate?

A Yes.

Q Is that -- does that appear to be a system-wide issue with the Indiana Department of Correction? Is it a training issue? Like why do you make that conclusion?

A Well, I can only speak for the medical records that I read, and the depositions that I read, and my understanding that these individuals are not members of WPATH or haven't received training in this highly specialized area of medicine.

Q But you agree with the decision to administer hormones to the plaintiff; right?

A Yes.

Q Would you have the same opinion if you knew that another prisoner at the Indiana Department of Corrections was approved for surgery?

MR. FALK: Sorry, what opinion? Is your question

about an opinion? I apologize.

MR. CARLISLE: Yes.

Q Is your -- would your opinion that plaintiff's mental health professionals do not have sufficient experience to treat gender dysphoria, would that opinion change if you knew that another prisoner at DOC was approved for surgery?

A No, that would not change my opinion.

Q How long did -- no. When did you meet with the plaintiff?

A October 23rd, 2023.

Q For how long did you meet with the plaintiff?

A I think two hours or so.

Q Was anyone else there during that meeting?

A No. It was a videotaped -- it was held over videoconferencing.

Q During your meeting with the plaintiff, do you think the plaintiff told you the truth about everything she represented to you?

A I think that the plaintiff expressed her feelings to me in a frank and forthright manner. Whether or not every single specific -- there may have been some omissions in what she told me, but in general, she was -- she was straightforward, she was honest, and additionally one of the psychometric tests that I

administered has a validity component built into it, which detects malingering, fabrication, dishonesty, et cetera.

Q You stated there may have been omissions made during your meeting with the plaintiff. What particularly are you thinking of?

A Well, I'm not thinking of anything in particular, but I think that there are certain things that people in prison are loathe to admit because there may be consequences if that's revealed, if I were to put that in a report, or they may neglect to tell me something about their history that they think might alter my opinion, but I didn't have any of those suspicions with Ms. Cordellioné. I mean she was forthright about her self-harm and her history, and of course I reviewed all of her medical records and took a very thorough history, as I've been trained to do.

Q So to your knowledge, based on your review of the medical records, the plaintiff did not affirmatively misrepresent anything during your meeting with her?

A I can't say that for sure. And I certainly don't recall as I sit here now every single aspect of our conversation.

Q Are you aware that the plaintiff has admitted to manipulating medical professionals to get things like

drugs?
A I am aware that the plaintiff can be manipulative, yes.
Q And what role did that knowledge play in your evaluation of the veracity of her self-reports during your meeting?
A It didn't at all impact on my determination that surgery is indicated for her.
Q And why is that?
A Because she has severe gender dysphoria, and whether or not she was -- did you use the term veracity? Was I --
Q Yes.
A No. I mean unless -- there was nothing in there in our interview, in the medical records, in my experience that would stop me or preclude my determination, my concern of what was vital for that particular patient.
Q And what is the mental health professional's role in evaluating a patient like you did in determining veracity of patient reports?
A Well, mental health providers are not fact-finders, so it's not our job to verify every single statement that an individual tells us. Basically the mental health provider is having a therapeutic interview with a

client, and when a psychologist is trained to determine whether -- whether or not a person is being reasonably forthright or if they have a motivation to dissemble; is there a secondary gain, what would they gain from lying to me, what would a person living in a male prison gain from taking hormones and appearing as female, what would be their -- what would be the -- how would that be them manipulating me?

So my training is really not just to listen to what a patient says but also to understand affect and to understand all of the other subtle elements of interview. So in a way, it's like when you listen to a song on the radio, you hear the words, but you also hear the music. So I'm not trying to verify every single thing that a patient tells me. I'm trying to understand the phenomenology of the individual, what condition they have, what treatments they receive, how they've responded to those treatments, what their current status is, and what is medically indicated for them currently.

Q Do you agree with the plaintiff that two hours is an insufficient amount of time for a mental health professional to really get to know a patient?

MR. FALK: I'm going to object to representation made by -- made by the plaintiff. You can certainly

ask the doctor if she thinks that's a sufficient amount of time, but I don't think appropriate to characterize what the plaintiff said when the plaintiff is not here.

Q You can answer.

A Would you repeat the question?

Q Do you agree with the plaintiff that two hours is an insufficient amount of time for a mental health professional to really get to know a patient?

A To really get to know a patient?

Q Yes.

A I think two hours is probably insufficient time to really get to know anybody; however, I don't think it's an insufficient amount of time for a specialist like myself, who has a singular task, which I've been trained to do and have done for decades, to evaluate whether or not an individual needs medically necessarily treatment.

Q Doctor, apart from the plaintiff's self-reports, is there any evidence that this plaintiff has severe gender dysphoria?

A Sure. Yes.

Q And what is that?

A She's been diagnosed with gender dysphoria.

Q Based on her self-reports.

A I'm sorry?
Q Based on self-reporting; right?
A No. She received a diagnosis from -- from the Department. She met the criteria and received a diagnosis, and based on that diagnosis, someone deemed her a candidate for cross-sex hormones.
Q Are you referring to the mental health professionals whom you said lack experience in treating gender dysphoria?
A Yes. Someone in the Department diagnosed her with gender dysphoria and initiated hormone treatment, and she meets the criteria according to the DSM-5.

Was there a further question there?

Q Yes. I guess anything else?
A Anything else regarding?
Q So my original question was apart from self-reports, what evidence is there that this plaintiff has severe gender dysphoria. You indicated her diagnosis. Is there anything else apart from self-reports and her diagnosis?
A Her behavior.
Q What do you mean by that?
A I mean her ideation and attempts to remove her own genitalia, her social transition, her -- the development of secondary sex characteristics,

consolidation of a female identity while living in a male prison, a continued distress, very significant distress, she displays around her genitals, her -- she takes a shower and doesn't undress completely because she doesn't want to look at her genitals. There's a severe amount of anatomical distress around her primary sex characteristics, and she has the typical tell-tale signs of an individual, who despite being steady on cross-sex hormones, still experiences a significant degree of gender dysphoria.

Q Doctor, what -- you mentioned the plaintiff's distress over the appearance, the presence of her genitals. What evidence do you have that that distress has resulted in significant -- clinically significant impairment in social functioning or ability to work?

A Well, I don't consider those criteria in terms of people who are living in a prison situation who don't have to maintain a normal occupation or live within a family or, you know, otherwise socialize. So in the prison context, there are other implications of clinically significant distress.

Q So in the prison context, the social or occupational functioning of the patient is not a relevant consideration or criteria of the diagnosis?

A It can be or it cannot be, depending on the

individual. The criteria for the diagnosis is clinically significant distress.

Q Or impairment in social, occupational or other important areas of functioning. Are you aware that the plaintiff has a job?

A The operative word there being or.

Q Are you aware that the plaintiff has a job?

A I don't know at this point in time if she has a job or not currently.

Q Are you aware that the plaintiff socializes in prison?

A Plaintiff did discuss some social situations in prison.

Q Do you have any evidence that those two areas, occupational or social, are impaired in her functioning?

A I don't have that evidence, no.

Q Doctor, you said that in the prison context, this DSM element of clinically significant distress or impairment in social, occupational or other important areas of functioning does not apply equally as in the community; is that accurate?

A It may not apply. It may not apply in the same way that it would in the community.

Q Doctor, I thought WPATH instructed that the guidelines have to apply similarly -- no, identically in prison

as they do outside of prison. Is that a misguided understanding?

A Yes, it is. The treatment.

Q But not the diagnosis?

A Oh, well, the diagnosis is established: Marked and sustained gender dysphoria is the diagnosis and the first criteria for surgery, marked and sustained gender dysphoria, a gender dysphoria diagnosis in regions where that's important, information about implications on reproduction, no other possible condition would explain the gender dysphoria, stability on hormones for at least six months, and the ability to provide informed consent.

Finally, no mental health or physical ailment contradicts the indication for surgery. That's the associated guidelines which are the necessary but not sufficient indications for genital reconstruction.

MR. CARLISLE: Do you want to take a break?

THE WITNESS: Yes, please.

MR. FALK: How much longer do you have, do you think?

MR. CARLISLE: I think -- let's go off the record.

MR. FALK: Oh, I'm sorry. Yes.

MR. CARLISLE: That's okay.

(A discussion was held off the record.)
BY MR. CARLISLE:
Q We're back on the record.
Dr. Ettner, how many transgendered prisoners have you evaluated?
A Well over a hundred in 20 different states.
Q Of those prisoners, how many have you been asked to consider whether a surgery is appropriate as a treatment option?
A Maybe 20 percent, 25 percent.
Q And of that 20 to 25 percent, how many have you recommended receive surgery?
A How many have received it or how many have I recommended receive it?
Q How many have you recommended should receive surgery in your opinion?
A Of those that I was asked to opine on whether surgery was necessary?
Q Correct.
A Probably 90 percent of that group.
Q Of the 10 percent that you did not recommend for surgery, what, if you could generalize, was the reason or what were the reasons for not recommending surgery?
A Primarily two reasons: One was severe mental illness psychosis and a detachment from reality, even though

they did have gender dysphoria, and in the other cases, they had not met the criteria for readiness.

Q Okay. How many expert witness reports have you submitted on behalf of transgendered prisoners who have filed lawsuits?

A How many expert witness reports -- would you repeat that?

Q How many expert witness reports have you submitted on behalf of transgendered prisoners who have filed lawsuits?

A Well, I've worked on some class-action suits that involve numerous prisoners, named plaintiffs and unnamed plaintiffs. I honestly don't know the answer to that question.

Q Those reports would be in your CV; right?

A No. They're not in my CV.

Q Okay. So --

A So I have written reports on cases where I've been retained for prisoners, not all of those have been regarding surgery.

Q Have they all been related to the treatment the prisoner has received for his or her gender dysphoria?

A No.

Q Well, can you estimate that figure? How many expert reports have you submitted on behalf of transgendered

prisoners relating to their treatment in prison for their gender dysphoria?
A I would have to count. I would have to go back and actually look in my files, otherwise I'm just guessing.
Q More or less than 50?
A Reports for people regarding treatment for gender dysphoria in prisons?
Q Yes.
A I would say less than 50.
Q Closer to 10 or 20? Just an estimate. I'm not going to hold you to these numbers, just want an idea.
A Closer to 20 definitely.
Q Okay. So more than 20, less than 50?
A Well, encompassing all aspects of treatment, including, you know, psychotropic medications, accommodations, transfer to a different prison, things like that.
Q My question is of those reports, do you -- do you always include a section about the risk of suicide or self-harm if the treatment is -- the course of treatment is not changed in some manner?
A No.
Q When do you not include a section like that?
A When it's not appropriate to the -- to the matter that

I'm addressing.
Q Okay. How many -- how many times have you indicated in a report that there's a possibility of suicide or self-harm risk for a transgendered prisoner?
A As many times as I've felt that the person was at risk for suicide or self-harm.
Q Do you do that for any time surgery is the subject of the report?
A No, not necessarily.
Q When would you not include that for a surgery report?
A It would depend on the individual that I'm assessing, their level of resilience, how long they've been in custody and other factors, are they in jail, are they on hormones, how long have they been on hormones, etc. I mean every person is an individual, so it would depend, but there is a risk of three trajectories for individuals who have severe gender dysphoria and are in imminent need of treatment, and I will discuss those if I think it's applicable.
Q If you could look at your report, Exhibit 45, page 25, please.
A Sorry. This is going to take a minute.
Q Take your time.
A It doesn't help that I can't see very well either, so hang on. Did you say 25?

Q Yes.
A Got it.
MR. FALK: Excuse me.
Q All right. In the top paragraph, second sentence, you indicate that the plaintiff's care providers have noted no suicidal ideation. Do you see that?
A Yes.
Q And I understand that is based on the initiation of hormones since 2020; correct?
A I think so, yes.
Q Let me ask you, Doctor, is there any evidence you've seen to suggest that this plaintiff is at risk for suicide attempt?
A The plaintiff has, I believe, six prior suicide attempts, and prior suicide attempts are the single-most influential factor in predicting completed suicides. So when someone has prior suicides, they're always at a higher risk than individuals without a history of suicide attempt.
Q You understand those prior suicide attempts were before the plaintiff received a diagnosis of gender dysphoria; right?
A Yes.
Q And how does that affect the analysis of suicide risk?
A It makes it less likely.

Q Is it accurate to say that the plaintiff's course of hormone treatments has lessened her suicidal ideation?
A Yes.
Q If you could go to page 22 and 23 of your report, please.
A Okay.
Q All right. 22, the bottom, the last sentence you write, for transgender women residing in carceral settings, ideation about surgical self-treatment, auto-castration or auto-penectomy or actual attempts are a tell-tale sign that treatment is inadequate and surgical intervention is medically necessary.

Do you see that?

A Yes.
Q And then you go on to write, Ms. Cordellioné did once attempt penile ligation, and that footnote 4 --
A Yes.
Q -- attempts at surgical self-treatment should not be viewed as evidence of uncontrolled mental illness. On the contrary, such behavior represents a rational intention to eliminate the testosterone by removal of the androgen-producing target organ.

Did I read that right?

A Yes.
Q When you say rational in footnote 4, is that a typo?

A No.
Q Are you concerned that by characterizing self-ligation attempts as rational, it will encourage more prisoners with gender dysphoria to attempt self-harm?
A No.
Q Did you tell this plaintiff that a ligation attempt is rational?
A I don't recall telling her that.
Q Tell me about the -- the note in your report that we just read about the plaintiff did once attempt penile ligation.
A What would you like to know about that?
Q What did the plaintiff tell you about that incident?
A That they used some device to attempt to strangulate the penis or the -- was it penal ligation? Yes. And the pain was very -- it was very painful, so on that occasion, they stopped.
Q So ligation, that's an attempt to cut off the blood flow?
A To strangulate the testes or penile. Prisoners use any number of devices. Dental floss, string, rubber band are common.
Q And this plaintiff told you she attempted to do this to her penis, and do you know when she attempted to do this?

A I don't recall as we sit here now precisely when.
Q Do you know any of the circumstances about where she was or what she did after? I mean do you have any more details about that?
A Not that I recall, only that ideation and attempts at ligation strangulation or cutting are incredibly frequent, and Brown & Brown and McDuffie have documented that extensively in the literature, and in my own experience of meeting with countless individuals and reading tens of thousands of medical records, people frequently will attempt ligation of the penis, the testicles or, if they have the opportunity to actually cut, they will cut the testicles.
Q This is not a -- I don't mean to be flippant when I ask this, but are ligation attempts painful?
A Sure.
Q Do prisoners who attempt ligation usually seek medical treatment after?
A Not typically. Typically what happens with these attempts is if cutting is involved, prisoners are frequently almost always unaware of the amount of blood when they cut the testicles, and the amount of blood is either -- becomes conspicuous, at which point they are found out and either -- and taken away,

treated. There's consequences. Sometimes the spermatic cords can actually retract, which is also a difficulty, and that causes severe pain, so many of these attempts are discovered.

Ligation can be hidden, so people will tie a rubber band around their penis, sometimes for a week at a time or as long as they can stand it, and we've actually had cases where people have flushed a penis or testicles down the toilet.

Q So would you be surprised if a prisoner claimed to have cut the scrotum but there's no indication that the prisoner received medical treatment after the cutting incident?

A No.

Q Even though cutting the scrotum results in a large amount of blood loss?

A It depends on how deep they cut and where they make the incision. Sometimes they are -- sometimes they're MedEvaced out to an emergency room depending on the amount of blood loss. Other times they're just -- you know, it's minor.

Q Would you be surprised to know that the plaintiff mentioned three testicular ligation attempts?

A No.

Q But the plaintiff did not tell you about those

attempts during your meeting?
A No.
Q Would you be surprised if the plaintiff didn't mention a penile ligation attempt?
A No.
Q On page 25 of your report --
A Okay.
Q Okay. There's a section on page 25, the heading, other possible causes of apparent gender incongruity have been identified and excluded. Do you see that?
A Yes.
Q And you point to a note in the medical records from Dr. Gale where he states he couldn't find any undiagnosed psychopathology to better explain the transgender identity of this plaintiff.
A I see that.
Q All right. And apart from relying on that note from Dr. Gale, is your conclusion in this section based on any other evidence?
A Yes.
Q And what is that other evidence?
A It was my evaluation of Ms. Cordellioné and my conclusion that she was suffering from gender dysphoria.
Q Okay. And how in your evaluation did you exclude any

other possible causes of her expressed symptoms?
A Well, I can't think of any other cause other than a psychotic delusion, you know, a person thinks that they're the Virgin Mary, something like that that might explain a desire to appear as a female. There was no other possible explanation other than gender dysphoria.
Q Did you -- what effect did the plaintiff's borderline personality disorder diagnosis have on your evaluation?
A It was something that I noted, and it was something that is -- was historically documented in her medical records.
Q And what effect did that have on your evaluation?
A It had no effect on her -- on my determination that surgery is medically necessary for Ms. Cordellioné.
Q What about any other current or historical mental health quote comorbidities that the plaintiff has or has had?
A If they render her so detached from reality, such as a labeled psychosis, dementia, some organic brain dysfunction, some bipolar psychotic episode that would prevent her from being capable of participating in a medical decision, providing informed consent. If she was detached from reality or had, you know, some

serious cognitive impairment, that would make her an unsuitable candidate for gender-affirming genital reconstruction.

Q Did you discuss the risks and complications of orchiectomy or vaginoplasty with the plaintiff?

A No, not in any detail.

Q What psychosocial difficulties do trans prisoners face, if you could generalize?

A What psychosocial difficulties --

Q Yes.

A -- do transgender prisoners?

Q Yes.

A The question?

Q Yes.

A What is the end of the question? Do they face?

Q Yes. What psychosocial difficulties do trans prisoners face?

A Well, I would be generalizing depending on the carceral institution, but in general appearing as a female in a male prison can be hazardous. It can leave an individual open to sexual exploitation. I had a case recently where a transgender woman would be sexually assaulted while she was sleeping, and so it can be a dangerous situation for an individual, and of course it can be -- they can be subject to social

difficulties. They may not have access to the healthcare or the female commissary items that would make them more comfortable. I, again, had a patient who didn't leave her cell for nine months, didn't shower for nine months because she was so fearful as a woman living in a male prison.

So depending on the prison, depending on the individual, depending on the cultural climate, depending on the staff, there's a great deal of variation, but it's never an easy -- it's not an easy objective. It's always challenging for a prisoner to come out and attempt to transition in a male carceral institution.

Q And is it fair to say that those generalized psychosocial difficulties you described prisoners facing are different than what trans people in the community face?

A Again, I think it depends on the situation. Depends on a person's socioeconomic status, it depends on their geographical location, their age. I mean there are so many factors. I mean Caitlyn Jenner probably had an easier time than someone living in rural Florida.

Q But you would agree that the prison context presents particular context that is not the same as a community

context?
A I agree that prisons are different than communities where people have access to care and people have agency that prisoners don't have.
Q Is this plaintiff receiving adequate treatment for her gender dysphoria?
A I'm sorry. I didn't hear you. You broke up.
Q Is this plaintiff receiving adequate treatment for her gender dysphoria?
A No. She requires additional treatment.
Q And -- and how do you know that?
A Because I evaluated her.
Q And so the only -- is the only reason that you say she requires additional treatment based on her self-reports during your evaluation?
A No.
MR. FALK: And I'm going to object just because it's been asked and answered, but you can keep answering. Sorry.
Q Apart from her self-reports, what other evidence do you have that her current course of treatment for gender dysphoria is inadequate?
A The treatment she's received so far has not eliminated her gender dysphoria. She experiences extreme distress, and she is attempting surgical

self-treatment, which is a tell-tale sign that treatment is insufficient and that hormones alone have not adequately attenuated the gender dysphoria.

Q Anything else?

A My experience in evaluating patients.

Q Of course. But I mean anything else particular to this plaintiff?

A Yes. I mean all of the -- all of the stigmata of severe gender dysphoria: Ligation, ideation, repeated attempts at -- of auto-castration or auto-penectomy. Her, she spends hours removing hair trying to remove the stigmata, the secondary sex characteristics. Her -- the inability to tolerate or even to talk about her male genitalia, her extreme distress about the incongruity of her primary sex characteristics.

Q And you know all that based on her self-reports; correct?

A No.

Q All right.

MR. CARLISLE: Let's go off the record.

(A discussion was held off the record.)

MR. CARLISLE: All right. We're back on the record. And, Doctor, at this time I have no further questions. I thank you for your time.

THE WITNESS: Thank you.

CROSS-EXAMINATION

BY MR. FALK:

Q Doctor, at the very beginning of this deposition you were asked who was present when you were prepared by your attorneys, and you mentioned I was present. Were other -- were Gavin Rose and Stevie Pactor there as well?

A Yes.

Q Just wanted to make that clear.

And -- and I apologize. This is probably because it involves numbers, and I'm not good with numbers. You had mentioned that there's a certain percentage of orthopedic surgeries of a certain type that are not based on randomized control trials and, in fact, based on low-level evidence. Do you remember those questions?

A I do, yes.

Q Could you -- could you tell me -- and maybe everyone else understood, but could you tell me what the percentages were we were talking about?

A Only one out of every 10 orthopedic surgeries are supported by rigorous scientific evidence.

Q Thank you. And you were asked a series of questions by Mr. Carlisle concerning whether there's debate about the efficacy of gender-affirming surgery or

perhaps also gender-affirming care in general. Do you remember those series of questions?

A Yes.

Q And are there individual practitioners who disagree with WPATH?

A Yes. I'm aware that there are individuals who disagree with WPATH, and who even disagree that there is such a thing as gender dysphoria or a need for surgery, but those individuals are -- fall outside of the mainstream of medical and scientific consensus.

Q Okay. And, Doctor, I think in response to my question about the -- where you gave the answer of 10 percent, that -- that 90 percent, what is -- what is that supported by, if anything?

A Well, the Cochrane reviews, which look at the evidence and the level of evidence for procedures, has determined that 94 percent of the procedures that they reviewed, which was 1,567, 94 percent of those procedures did not have significant high levels of evidence, that most of those procedures were based on guidelines and clinical consensus.

Q And by high-level evidence, do you mean things like randomized controls?

A Randomized controlled trials, double-blinded studies, you know, placeb- -- you know, the use of placeboes in

studies, rigorous scientific methodology.
Q Was only present for 10 percent of the surgeries or less than 10 percent?
A Correct.
MR. FALK: I have no further questions.
MR. CARLISLE: Nothing on those.
THE REPORTER: This concludes the deposition of Randi Ettner, PhD. Would counsel please state if they wish a copy of the transcript, any stipulations or other matters to be included in the record.
MR. FALK: Plaintiffs would like a copy. I can talk to the client off record, if that's okay, about signature.
MR. CARLISLE: Defendant would like a copy. E-tran is fine.
MR. FALK: An E-tran is fine for Plaintiff.
THE REPORTER: Do you both want exhibits attached?
MR. CARLISLE: Yes, please.
MR. FALK: Yes, please. Thank you.
(A discussion was held off the record.)
MR. FALK: We will take signature. Thank you. And the court reporter will e-mail that to me, and I'll e-mail it to you, and we'll review it as well because we want to relive the experience as well.

(The deposition concluded at 1:40 p.m.)